COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
OVERPAYMENT AND REPAYMENT INSTRUCTIONS

(COUNTY STAMP)

State number: _____

Name of beneficiary affected: _____

_____

Date: _____

We have determined that the CMSP has incorrectly paid $ _____ for your medical care for the month(s) of _____. This overpayment was the result of:

I. Share-of-Cost

❒ Your share-of-cost should have been $_____ because _____ and you did not report this information to the county.

The overpayment was computed as follows:

1. Month	2. Correct Net Income	3. Correct Maintenance Need	4. Correct Share-of-Cost (2–3)	5. Share-of-Cost You Met	6. Possible Overpayment (4–5)	7. Amount Paid by CMSP	8. Overpayment (Lower of 6 or 7)
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$
	$	$	$	$	$	$	$

II. Property

❒ You should have been ineligible for CMSP for the month(s) of _____ because you had countable, nonexempt property worth $ _____ which is $_____ above the property limit. CMSP paid $ _____ of your health care costs during this time. You are responsible for repaying $_____ (the lower of your excess property or the amount that CMSP paid).

III. Other

❒ _____

IV. Repayment Instructions

You are responsible for repaying $ _____. Send your check or money order for this amount to _____ within 30 days. The regulations which require this action are Article 14, Sections 0782 through 0786 of the County Medical Services Eligibility Manual, which define CMSP overpayments and your repayment responsibilities.

If you have any questions, please contact _____ at _____. You may request a hearing on this matter if you do not agree, by contacting your county welfare department.